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RESEARCH ARTICLE

Has the British National Health Service (NHS) got talent? A process evaluation of the NHS talent management strategy?

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In 2004, the British National Health Service (NHS), an organisation with one of the largest workforces in the world, adopted a new approach to identifying and developing managers, which was refreshed in 2009 with 'guidance for NHS talent and leadership plans'. This paper explores the introduction of talent management (TM) in the British NHS, focusing on process evaluation. It discusses the introduction of TM in the NHS before examining the stated principles, objectives and measures of TM in the NHS. It draws on a mix of research methods, including a literature review, focus groups, qualitative interviews with policy-makers, qualitative interviews with managers, a questionnaire survey, and qualitative interviews in high performing organisations. It is found that there are a number of issues that may undermine the TM strategy, including unclear definitions, conflicting principles, problematic measures; exclusive focus, sustainability; and lack of necessary infrastructure, culture and data.

Keywords: talent management; National Health Service; process evaluation; case study; England

Introduction

According to Chartered Institute of Personnel Development (CIPD 2006), the term talent management (TM) has become increasingly common in the world of 'human resources' (HR) since McKinsey first coined the expression 'the war for talent' (Michaels et al. 2001). TM has received a remarkable degree of practitioner and academic interest in the public and private sectors of many countries (see e.g. Collings and Mellahi 2009; Devine and Powell 2008; Lewis and Heckman 2006; Macfarlane et al. 2012; NHS Employers 2009; White 2009).

A working definition of TM as given by the Chartered Institute of Personnel Development (CIPD) (2008) involves: '…the systematic attraction, identification, development, engagement/retention and deployment of those individuals with high potential who are of particular value to an organisation'. Similarly, according to NHS Employers (2009), TM is essentially making sure you have the right person in the right place at the right time. It can be defined as attracting and integrating highly skilled workers and developing and retaining existing workers.

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According to CIPD (2006), the most frequent TM practices include in-house development programmes, coaching, succession planning, mentoring and buddying, graduate development programmes, courses at external institutions, internal secondments, assignment centres, 360-degree review, job rotation and shadowing, development centres, MBAs, action learning sets, and external secondments. Similar issues are stressed by NHS Employers (2009) who argues that TM typically consists of the following core components: chief executive engagement; diversity objectives; performance measurement; succession planning; development programmes; mentoring; and coaching. This is clearly a very mixed bag of HR activities.

A CIPD survey (2006) of over 600 responses that examine current attitudes and practices in relation to TM and development within UK organisations reported that 51% of respondents undertake TM activities, although only 20% report having a formal definition for it. TM is more common in the private (56%) than public (46%) or voluntary (30%) sectors, and in larger (61% for over 500 employees) than smaller (35% for less than 249 employees) organisations. Ninety-four per cent agree that well-designed TM development activities can have a positive impact on an organisation's bottom line.

However, Lewis and Heckman (2006, 139) point to 'a disturbing lack of clarity regarding the definition, scope and overall goals of talent management', while Collings and Mellahi (2009) agree that a cursory review of the TM literature reveals a degree of debate as to the conceptual boundaries of the topic. Ashton and Morton (2005, 30) note that no single consistent or concise definition of TM exists, while Chuai (2008) provides nine 'researcher' and five 'management consultant' definitions.

Moreover, knowledge on the effectiveness of TM is limited. First, while there are many success factors, steps, 'case studies', 'top tips' and checklists on TM (see e.g. NHS Employers 2009), there is limited robust evidence on effectiveness. Ford et al. (2010a, 2010b) argue that despite a vast outpouring of web- and paper-based discussions on the topic by management consultants, scientific studies of its effectiveness are almost non-existent, which means that the evidence base is lacking. Similarly, Lewis and Heckman (2006, 142) state that the core problem of TM is that it is rooted in exhortation and anecdote rather than data and builds an argument based the selective self-reports of executives, and is enthusiastically pursued in the trade and popular press without being linked systematically to peer-reviewed, researched-based findings.

Second, most of the work on TM relates to for-profit business in the USA, and transferring findings to other contexts such as the public sector in general (e.g. Devine and Powell 2008; White 2009) and the British NHS in particular (Ford et al. 2010a, 2010b) is extremely problematic. Similar to the wider high performance work systems literature, it is unclear what the appropriate 'bundles' of TM are, or if they are best practice (universalistic prescription), best fit (contingency) and configurational (Delery and Doty 1996). CIPD (2006, 2) suggests that there is no single 'blueprint' for effective TM that can be applied to all organisational contexts. Ford et al. (2010a) stress the importance of a 'organisation-specific' strategy. There are some studies on individual components of TM in a health care setting. For example, McKinsey & Company (2010) based on an assessment of 126 NHS and other hospitals across the UK, suggests that improved operational effectiveness, performance management and TM are associated with a number of success criteria, including lower infection rates, lower readmission rates, more satisfied patients, more

productive staff and better financial margins. Goodall (2011) reports an analysis of top-100 US hospitals in 2009 which shows a strong positive association between the ranked quality of a hospital and whether the CEO is a physician. Ford et al. (2010b) focus on TM in the Yorkshire and Humber Strategic Health Authorities (SHAs) in the UK.

This paper explores the introduction of TM in the British NHS. A summative before/after evaluation is not possible at this stage due to evaluation problems associated with distant success measures (e.g. in 2015: see below), lack of data and causality problems. This paper focuses on process evaluation, with a descriptive or audit evaluation design which describes the intervention in comparison to intended objectives, procedures or standards (see Ovretveit 1998). It discusses the introduction of TM in the NHS before examining the principles, objectives and measures of TM in the NHS (DH 2009; NLC 2010). In other words, it examines problems associated with stated principles, objectives and measures of TM. However, the differences between some of these categories are not always fully clear. As we will see, 'objectives' include five-year outcomes and some measures (on diversity), while some of the 'measures' are not measurable.

TM in the NHS

Although recent commentators stress the importance of management and leadership in the NHS (King's Fund Commission on Leadership and Management in the NHS 2011; West et al. 2011), the NHS has long been concerned about managing talent (mt). For example, the Management Training Scheme (MTS, previously known as the Graduate Training Scheme) is now 50 years old (Saunders 2006), with 'mt' initiatives discussed in many documents (NHSTA 1986; DH 1998, 1999, 2000; House of Commons Health Committee 1999, 2007), and have been the responsibility of a long list of changing national and regional organisations (the NHS Training Authority from 1981, the NHS Training Directorate from 1990, the NHS Leadership Centre from 2001, Workforce Development Confederations (WDCs) from 2001; and the NHS Institute for Innovation and Improvement (NHS III) from 2005). In 2004, the NHS adopted a new approach to identifying and developing managers with the establishment of a national TM team whose aim is to 'identify and position high potential individuals to have a disproportionately positive impact on the organisational performance' (DH 2004; Ford et al. 2010b, Macfarlane et al. 2012; Powell et al. 2012).

In July 2005, the NHS III became responsible for the three main initiatives of the TM programme: 'Gateway' (which identifies individuals from outside the NHS with the potential to fulfil director level roles); the 'Management Training Scheme' (MTS); and 'Breaking Through', which is a programme that provides a series of opportunities for Black and Minority Ethnic (BME) employees (NHS III 2009).

The National Leadership Council (NLC) was set up in 2009 with the four of five workstreams concerned with managers: Top Leaders; Emerging Leaders; Inclusion; and Clinical Leadership (the other is Board Development). In January 2009, the DH (2009) published its 'guidance for NHS talent and leadership plans (TLP)'. This required SHAs to produce TLP by July 2009. However, almost as soon as TM was seen as an organisational imperative, TM entered a cold climate with a 'double whammy' of the need to make management savings and organisational change. The most significant organisational change was signaled in the Coalition government's

White Paper, *Equity and Excellence* (DH 2010), which set out plans to abolish PCTs and SHAs. Under the review of 'Arms Length Bodies', the NHS III is set to be abolished. On 5 July, Health Secretary Andrew Lansley marked the 63rd birthday of the NHS by announcing plans for a new national Leadership Academy (DH 2011a).

The NHSFF (2011) set up four groups (of which two are relevant to TM) which fed into the main report. The overarching recommendation of the NHSFF Clinical Advice and Leadership Group (2011) was that multi-professional advice and leadership should be visibly strengthened at all levels in the system. The NHSFF Education and Training Group (2011) pointed to the unclear transition arrangements associated with the abolition of SHAs. In August, the government reported the summary of consultation to its workforce plans (DH 2011b). It stated that the broad principles such as responsibility of employing organisations for workforce issues, and multi-professional training were welcomed. The responses to the consultation suggested that it would be important to embed leadership into all levels of training and development, which must be coupled with good staff appraisals and continuing professional development (CPD).

Principles, objectives and measures of TM in the NHS

The main vision, principles, objectives and short- and long-term success measures are set out in two main documents: the Talent and Leadership Guidance Plans (DH 2009) and the review of the first year of the NLC (NLC 2010). According to the DH guidance, the vision for talent and leadership for quality is that we are spoilt for choice where everyone counts and we are as focused on our leadership development as on our clinical outcomes and financial management so that we provide better patient outcomes and ever increasing public confidence (DH 2009: 10). The plan should set out a three- to five-year vision, and obligations laid out in the NHS Constitution need to be addressed (18). It is stated that behaviour change may be required to develop a culture which fosters leadership development for quality. Earlier work with four SHAs identified five areas where behaviour change may be needed: taking succession seriously; creating consistency and transparency of process; demonstrating boldness and openness; willingness to steward talent across the system; valuing diversity across the system (27).

The main stated principles are: co-production (all parts of the system working together); subsidiarity (ensuring that decisions are made at the right level of the system as close to the patient as possible); clinical ownership and leadership (clinicians on board); and system alignment (the different parts of the system pulling in the same direction) (DH 2009, 17). However, it is important to note that these 'principles' relating to the wider NHS, and are not drawn from any 'principles' or evidence base of TM.

Turning to objectives, initially the prime focus will be on Aspiring Chief Executives (ACE) and Aspiring Directors (AD) programmes. However, in the longer term, it is anticipated that the five-year outcomes for SHAs will include ensuring a systematic approach is in place; increased leadership supply, including clinical leaders; and with leaders reflecting the workforce and the communities they serve (particularly BME, women and disabled people) (DH 2009, 11–13).

Finally, measures to ensure readiness for TLP will include the SHA chair and CEO personally and demonstrably lead the improvement of leadership capacity and capability both within the SHA and across the regional system, and this is likely to be more than 20% of CEO time; there is a named SHA Board director who leads on improvement of leaders; action plans in place that are consistent with the four principles; the plans will address the necessary infrastructure, culture and data for collaboratively delivering sustainable improvement; and that the SHA board can demonstrate that it is satisfied with how they will improve the TL dashboard measures, particularly for clinicians, those from BME backgrounds, women and disabled people (DH 2009, 15).

Similarly, NLC (2010) gives 'short-term measures' as at least three appointable candidates apply for each senior manager vacancy, senior management body reflects the gender and the ethnic mix of the population they serve, a 'demonstrable improvement' in the proportion of clinicians in senior management position (around 5% CE are doctors, and 15% are clinicians), regions have plans for improvement with a third of leaders on talent development programmes for CE roles being clinicians (11). The success measures in 2015 are to be SFC where leaders are appointed and in the opportunities available to aspiring leaders, where everyone counts with the profile of leaders reflecting the workforce and the communities they serve with more clinicians in leadership roles where we have a reputation for 'world class leadership' with leadership development as important as finance or quality for boards where organisations have leaders who are rated as highly effective (10).

Research Methods

The research design was a mixed method quantitative (questionnaire) and qualitative (interview, focus group) examination of how four different cohorts of managers navigate the multiple routes through their careers. It consisted of a quasi-probability element that focuses on a maximum variety sample and a purposive element that seeks policy views at central and SHA level, and examined TM in high performing NHS organisations. Fuller details are available in the project report (Powell et al. 2012, but in brief, the research was conducted in six separate stages:

(1) Literature review: structured search using a number of terms such as 'talent management' from a number of databases; and documentary analysis of DH and SHA documents.
(2) Two 'heterogeneous' (age, gender, organisation, professional backgrounds) sets of focus group of managers in late 2009 (13 managers) and late 2010 (11 managers) (denoted as FG below)
(3) Qualitative interviews with those responsible for TM at national and SHA levels (22 interviews to cover central and SHA perspectives, conducted in December 2009/January 2010, with two in June 2010). (denoted as A–X below)
(4) Qualitative interviews with four cohorts of managers from a variety of socio-demographic and education backgrounds in a variety of roles in different organisations. The first tranche of potential candidates were identified from the expertise, knowledge and contacts of members of the project team. Our aim was to produce a response sample of around 60 managers and to ensure

we covered potential differences by gender, ethnicity, age, seniority, NHS organisation, region and cohort. Subsequent potential candidates were identified through 'snowballing'. A total of 42 interviews were completed, as both reviewers agreed that data saturation had been reached (denoted as 1–42 below).

(5) Questionnaire Survey focusing on basic career histories and experiences of TM and mt provided the 'breadth' component to 'depth' of cohort interviews. The survey was piloted, and open to respondents between July 2010 and the end of September 2010. The main problem was the lack of a single sampling frame of NHS managers (like the Medical Register), and so a variety of databases were used, resulting in 556 usable responses which equated to a response rate of 3.7%, and amounting to about a 1.2% sample of the nearly 45,000 NHS managers, which were roughly representative of age, gender and organisational type. In addition to quantitative data, we also collected 'free text responses' (denoted as SFT below).

(6) Exploration of NHS Staff Survey and qualitative (interview) examination of TM in five high-performing organisations. We wished to select five HPTs representing different organisational forms, but external factors (the decision to abolish PCTs; research ethics and governance) led to two of the five organisations being dropped from parts of the analysis, leaving a non-FT Acute Provider Trust (APT); a Mental Health Trust (MHT); and Ambulance Trust (AT). Interviews were conducted with the TM lead, and other staff at each Trust. Six interviews were completed at our Ambulance and Mental Health Trusts, and seven at our Acute Provider Trust. The interviews took place between the beginning of October 2010 and the end of January 2011 (denoted as APT, MHT, AT 1–7 below).

We followed Silverman's (2006) suggestions to enhance the overall reliability of qualitative research: thorough pre-testing of interview schedules by comparing how at least two researchers analyse the same data; conducting the interviews as far as possible under standard requirements; and presenting 'low-inference descriptors'. These are seen as tape-recording all face-to-face interviews; carefully transcribing these tapes; and presenting long extracts of data in the research report (Silverman 2006, 287).

Results

Principles

The main stated principles are co-production, subsidiarity, clinical ownership and leadership, and system alignment (DH 2009). This section explores adherence to and conflicts between these stated principles. There appears to be some tension between some of the principles. Recent developments seem to stress subsidiarity in devolving most workforce issues to employing organisations. However, this may conflict with co-production and system alignment. Indeed, interviewees were divided on whether the NHS comprised a 'system'. There was some discussion whether it was possible to have the sort of TM that leading private sector companies have, as private companies are single organisations that are more able to 'direct' talent:

> 'not like one company such as Microsoft with TM scheme. More unified approach to TM as they do in the private sector is more difficult.' (2: sources of quotations given in 'Research Methods' above)

There were some different views on whether the NHS should follow the private sector lead in TM, or whether TM in the public sector was distinctive. Some considered that the private sector led the way in TM:

> 'Private company managed their talent really well . . . you're flagged as talented . . . they get rid of dead wood'. (27)

> 'ICI- they have really robust succession planning, so that any time they will know from their employees all over the world who are the sort of rising starts, who are destined for the next top jobs'. (19)

On the other hand, some stressed that the public sector may be fairer than the private sector:

> 'There were lots of obstacles in the UK banking industry . . . the public sector was far more friendly and welcoming'. (BME, F)

A related point is whether there was a 'system' in the NHS, or a collection of organisations, which had implications for whether the 'system' was competitive or collaborative. It is unclear:

> '. . . whether the NHS is a system, an organisation or a set of different organisations'. (F)

There was a:

> 'fundamental difference of view between some people who see the NHS as a single organisation and those people who see it as a sector made up of individual and increasingly independent players'. (E)

There were some strong arguments for a collaborative system:

> 'CE sometimes jump up and down and say how dare you 'poach' this person, but I regard them as the property of the system and not the property of your organisation'. (9)

> 'To some extent TM requires an element of altruism', (C)

However, there were equally strong arguments for a more competitive system:

> 'In what sense has the DH or NLC to intervene in terms of how a particular FT approaches the development of its staff? They are its staff, they are not the NHS' staff, . . . Hoarding your best staff is absolutely what you should do as leader of an NHS organisation'. (E)

The principles were problematic in four ways. First, the combination of some flexibility and differing local circumstances results in variation between and within SHAs:

> 'All SHA have moved on at different rates and have had different issues and problems'. (8)

> 'Variation around the regions- different culture; different sets of issues'. (C)

Second, there was limited subsidiarity for some organisations.

> 'We have to submit TM plans. I don't know that it was terribly useful . . . We do something and then a few months later there's a central or regional dictat that says you must do x, y and z but we may have dome it already but in a different format. It can lead to organisations not wanting to be very proactive because what is the point of getting on with it when you are going to be told in the future to do it'. (41)

FT had more autonomy. The number of FT varied by SHA, and SHA had no direct line control over them:

> 'We are 'very FT rich'. We have no authority over FT; have to work by agreement and partnership because we can't require)'. (1)

This led to differential engagement of FTs. Some did not want to 'play ball':

> 'The current initiative can drive TM to PCT but not FT. Some FT will be happy to play in that territory, others see no need'. (C)

However, the increasing subsidiarity associated with current policies might lead to greater variation:

> 'It may highlight differences between organisations- some may be more willing to continue to invest than others'. (4)

Third, there were some concerns about the alignment between programmes, which were not always 'joined up':

> 'Not clear who is responsible for what'. (9)

> 'The national and regional programmes do not link well, for example where does Gateway fit with ACE?' (SFT)

Fourth, whatever structure or 'system' is in place, its impact will vary due to 'agency' reasons; that managers and staff will vary in capacity, skills and motivations:

> 'TM can get marginalised. It depends on the way individual managers and leaders work with their staff'. (38)

> 'It depends on who your boss is and what their motivations and interests are'. (41)

The broad consensus was that TM was more of a system than earlier 'tm', which contained many similar elements, but they tended to be rather ad hoc and variable. The picture was 'very mixed', ranging from 'excellent' to 'pretty woeful'. Networks were important, and patronage was potentially a major problem.

> 'The system was broadly supportive, but it was more ad hoc and informal rather than structured or planned'. (1)
>
> '[Worked in NHS HR in late 1970s] I cannot remember anything very proactive around "TM" . . . mainly reactive and passive'. (8)

The new TM system was regarded as more 'joined up' and 'systematic':

> 'The first time that we have systematically objectively provided an opportunity to review talent at many levels within the system. By making it more systematic, what we're doing is levelling the playing field'. (10)
>
> 'First time NHS has taken a proactive and systematic approach to development'. (SFT)

There were some concerns about the future system alignment of TM, given that previous initiatives have not been sustained, and the competition for resources in a more austere funding era:

> 'Littered with a track record of failure around this'. (I)
>
> 'You are not going to develop a TM system that has results within a few years'. (7)
>
> 'Hope it is here to say this time, not another false start; need sustainability'. (J)
>
> 'All the benefits of TM in terms of organisational memory . . . will be lost as SHAs and PCTs are disbanded. We all have to start again'. (SFT)

There was significant support for the principle of clinical ownership and leadership, particularly in our HPTs:

> 'I don't think there was an emphasis in my early years on the value of clinical leadership; now investing a lot of time and money in clinical leadership' (MHT 4 - nurse)
>
> 'very passionate about [TM] as we never got any leadership training at medical school, or as a junior doctor or registrar'. (APT 3 – doctor)
>
> 'the clinician is king at the moment. A peculiarity of the health service. It is amazing how many NHS mangers had a clinical background but almost seem to abdicate it or become divorced from it in order to make themselves more credible as a manager. There was a culture where you were not credible as a clinician in a management position but now it is the other way around'. (AT 4 – paramedic)

However, progress was fairly slow:

> 'I am not sure we are making enough efforts to increase the number of very senior managers who come from a clinical background'. (16)

Objectives

The initial focus on ACE and AD tends towards the exclusive rather than an inclusive perspective on TM (as set out in DH 2004). The original McKinsey approach focused on 'top talent' or 'A players' (Michaels et al. 2001), but most of our interviewees favoured a broader inclusive approach (cf. Ford et al. 2010a, 2010b).

> 'Can become too targeted at senior and very senior managers'. (SFT)

> 'Could be exclusive . . . if not handled right'. (SFT)

> 'The important thing for me about TM is not just managing the high powered talent, it's the every day talent'. (H)

> 'need the not quite so bright and not quite so best as well as the brightest and the best'. (I)

In particular, our HPT appeared to take a more inclusive approach to TM, with CPD cascading further down the organisation; and not confined to ACE and AD:

> 'I see TM in terms of managing the whole of the workforce rather than the higher levels that the SHA seems to be concentrating on'. (APT 1)

> 'I strongly believe that TM should not stop at people who are at AD level'. (APT 2)

Moreover, there was some significant criticism of the Top Leaders Programme due to reasons of selection and transparency, and the effect on the morale of those not chosen:

> 'Concept of TL causes a lot of anxiety. Real dangers of it becoming around patronage'. (F)

> 'Lack of transparency in selection of the talent pools; for example Top Leaders led to suspicion and resentment'. (SFT)

The long-term objectives (DH 2009; NLC 2010) were to ensure a systematic approach is in place, with an increased supply and diversity of leaders. This can only be assessed after 2015, but there appear to be some problems and inconsistencies in the documents. In particular, the self-assessment summarised in Table 1 hinges on the concepts of 'RAG status' and being 'spoilt for choice' (SFC).

Table 1. SHA dashboard status: red, amber, green analysis (RAG).

SHA	CEs ready now	CEs ready soon	Directors ready now	Directors ready now
East of England	Green	–	Amber	–
East Midlands	Green	Green	Green	Amber
London	Amber	Amber	Red	Green
North East	–	–	–	–
North West	Green	Green	Green	Green
South Central	–	–	–	–
South East Coast	–	–	–	–
South West	–	–	–	–
West Midlands	–	–	–	–
Yorkshire and the Humber	Green	Green	Green	Green

Source: SHA TLP.

Although being 'spoilt for choice' (SFC) is a key theme of the guidance, nowhere is it clearly defined. The key is 'RAG status' which is the ratio of actual to demand, with *R*ed being equal to or under 1.0, *A*mber being between 1.01 and 2.99, and *G*reen being at or over 3.0 (DH 2009: 24–5). The 'Spoilt for choice' diagram sets out demand, supply and gaps for 'ready now' talent (0–1 year) and 'growing' (or ready soon, 1–3 years) talent for CEs and Directors. 'Encouraging more clinicians to become leaders' identifies the percentage of ready now talent pool for CE who are clinicians and doctors. 'Reflective of our communities' gives the percentage of the 'ready now' talent pool for CEs who are from BME backgrounds, women or those who have a disability. A RAG status of green assumes that 'actual' must be three or more times 'demand'. Most SHAs multiplied predicted turnover (demand) by three to reach 'desired'. However, this assumes that the two unsuccessful applicants for Interview 1 will never be interviewed subsequently, and that Interview 2 requires three *different* interviewees. Making a different assumption that unsuccessful interviewees in Interview 1 will appear at subsequent interviews gives a rather different figure of N + 2 rather than N*3. This suggests that in quantitative terms the SFC 'desired' figure significantly overestimates the required talent pool, and so the NHS is more SFC than it appears.

On the other hand, there are indications that the SFC 'desired' figure may underestimate the required talent pool on qualitative grounds. Most of the SHAs stress that the figures in their first plan are crude, and much work is required to increase their validity. For example, as a first approximation some SHAs equated their talent pools with 'Aspiring' people on courses. In other words, it is assumed that everyone on ACE courses have the potential to be a CE, or that the translation rate is 100%. However, this is unlikely to be the case (see below).

Similarly, there is some conceptual confusion about the targets for under-represented groups. The DH guidance was unclear about whether the target should reflect the population or the workforce. However, these can be rather different. For example, the gender target would be about 50% if based on population, but about 70% if based on workforce. The DH guidance stated that there should be *higher* levels of clinical and medical representation in senior management, but little information about the current situation nor indicative targets were given.

SHAs stressed that their July 2009 plans were a first effort, and that much work was required to improve data in subsequent years. As Table 1 shows, there is some variation in SFC data for the SHAs that gave comparable data. Some SHAs such as East Midlands, North West and Yorkshire and the Humber claim to be SFC for most or all of the categories. Indeed, NHS Yorkshire and the Humber (2009, 13) state that low turnover of CE and the relatively high number of aspiring individuals could present the region with a unique problem: *'it may become necessary to manage expectations of this particular talent pool who could be faced with stagnant career prospects'* (p. 13). On the other hand, it is likely that the 'supply' data overestimates the available talent so that SHAs may not be really SFC. For example, NHS West Midlands (2009) considered that 5 of the 63 individuals (8%) on the ACE, and 22 of the 88 individuals on AD were 'ready now'. The supply figures in West Midlands tended to be below 'demand' (projected vacancies), let alone 'desired' (vacancy*3), but a more lenient definition of 'readiness' may have seen West Midlands SFC.There appear to be no consistent targets for clinical and medical representation. For example, the NHS North West (2009) SHA target is 25% of the CE talent pool with a

medical background and 50% of the talent pool for CE with a clinical background. In the NHS South West (2009), some 27% of CE are clinicians, and the SHA has set the ambitious target of increasing this to 50% within the next 5 years. Some 63% of participants on the Top Leaders programme hold a clinical qualification of which 38% are doctors.

Most SHAs recognise that BME staff in existing senior management and talent pipelines are not representative of the workforce or community. For example, the data on senior management 'does tell a familiar story that is of little surprise. The senior leadership population is predominantly white, male, and in the higher age brackets' (NHS YH 2009, 10). This is a stark reminder that considerable work needs to be undertaken to enable the progression of individuals from BME backgrounds to senior positions: less than 4% of combined Band 8 workforce originates from a BME background (11).

The situation appears to be more optimistic in terms of gender, but is blurred by the unclear target, depending on whether it is set in terms of population or workforce. Most SHAs did not present data on disabled people, but the few that did showed that they were relatively disabled people in senior management or the talent pipeline.

There was broad consensus in the interviews that NHS leadership was not representative of workforces or communities:

> 'We are acutely aware that we have got very low percentages of people, for example, from BME, but we have had some senior people from BME background saying, the last thing I want you to do is to over-promote and tokenism, because that will actually undermine the case'. (J)
> 'It is ageist, sexist, racist and all about who likes you because you flatter senior managers and look and act like them'. (SFT)

There were concerns that the NHS was too slow on its inclusion agenda:

> 'I think David Nicholson[Chief Executive of the NHS] is right to be impatient about inclusion. I don't think we have moved anywhere near fast enough on that'. (18)

> 'The NHS recognises in theory, but I'm still not sure whether it recognises in practice, the value of diversity in its leadership community . . . I think you'll find the further away you get from London the whiter and more male it becomes'. (24)

However, some pointed to problems of preferential routes:

> 'it almost felt that there was a route in through there for people of a BME background and it put us at a disadvantage who aren't of a BME background. So I think it is about a balance'." (FG)

> 'TM very much geared to around BME and female staff. I don't feel it is an even handed approach in this area, which is slightly disappointing for me as a white middle class male'. (4)

Focus Group participants pointed to a very different and often neglected sense of diversity in a very different sense – 'mavericks' who think and possibly behave differently from others, and who will challenge the system. Some commentators such

as Page (2007) consider that 'cognitive diversity' (thinking differently) is more useful than 'identity diversity' (gender, race):

'Your talent spotting processes can be quite subjective because you might be somebody who seems a bit of a maverick because of the organisational culture'. 'If your face doesn't fit often you're not spotted, then you're ignored or sidelined and often if your face doesn't fit it's because you've challenged the status quo or you're different . . . And yet they're the people we need. . . . . So for me, diversity is about taking risks with who we recruit and who we develop and really develop those people who challenge the status quo'.

> 'Just feeling that I was not on the list of people who were allowed to get Director jobs in the NHS' . . . Conformity is more important than talent'. (9)

Measures

The main problem here is that some of the 'measures' do not appear to be easily measurable. There was little indication from the SHA TLP that leading the improvement of leadership capacity and capability SHA chair and CE accounted for more than 20% of CE time. Neither was it easy to spot the 'named SHA Board director who leads on improvement of leaders'. As we saw above, it is difficult to identify 'action plans in place that are consistent with the four principles' as some of the principles appear to be problematic and in tension with each other. As the issue of Dashboard measures has been discussed above, this section focuses on whether plans would address the necessary infrastructure, culture and data for collaboratively delivering sustainable improvement.

It is not clear if the necessary infrastructure or data to identify talent exists:

> 'Identifying talented managers is the "million dollar question"'. (1)
>
> '"It still relies quite a bit more than it should on individual spotting'. (11)
>
> 'Need more rigorous and transparent process'. (7)
>
> 'Judgements a little bit subjective and parochial and runs the risk of missing some good people'. (A)

There was often a lack of consistency between and within organisations, so that different people had different views of 'talent'. In some cases, individuals' views of their talent were seen as optimistic, but in other cases talented people did not put themselves forward or were not spotted:

> 'Some person wants to be a Director and you kind of think 'well, dream on really' [laughter] Or you see people who seem to have no aspirations and you think "well why not, they're brilliant"'. (A)
>
> 'Some regions were saying that as more than 3 appointable candidates per interview we are SFC and therefore "green" of measure. But David Nicholson said you are not green, you are not scrutinising your talent pool tightly enough; my experience of sitting on interview panels is that is not the reality. Although people are saying they are SFC, it just doesn't feel as if the rigour is there yet'. (J)

This is partly linked to the lack of a common system or database:

> 'Need good data that is transferable across the NHS. Do not have a single TM platform or software system that we are all using so that we can compare like with like'. (5)

Another missing 'building block' was a robust foundation of Personal Development Plan (PDP) flowing from appraisals:

> 'Some of the very basic building blocks for managing talent are not universally there; you can't possibly be spotting talent if you don't have 100% and high quality appraisal processes in place; you are "missing a trick"'. (5)

The importance of appraisals and the links with PDP was recognised by some informants:

> 'Appraisal- quarterly reviews and yearly action plan. MSc was borne out of action plan'. (AT 4)

> '. . . identify development needs through PDP'. (APT 2)

It was broadly agreed that appraisals were beneficial in principle and there were some feeling that appraisals were getting better:

> 'I don't really think that in my early years [early 1980s] there were things like annual appraisal or kind of development reviews or anything like that'. (35)

> 'Appraisals have got better over past 5 or 6 years. More detailed and more honest'. (18)

However, the appraisal process was broadly viewed in negative terms in both quantitative and qualitative senses. Some pointed out that appraisals often did not take place at all:

> 'I have not been appraised in 20 years. I had one many years ago that was bit of a damp squib'. (21)

> 'My experience of the NHS is that there isn't really one [appraisal process]'. (27)

The majority view was that where appraisals did take place, their value was often seen as limited. However, 'mixed' experiences suggest that there are some good appraisal systems and appraisers, and 360 degree appraisal was generally seen as beneficial:

> 'We are performance managed on the number of staff that have appraisals every year and so there can be a surge to get these done in time; sometimes empty and rather tokenistic, going through the motions, can make appraisee devalued'. (25)

> 'Experience of 360 degree assessment was good, very reaffirming'. (34)

Some suggested that regular, informal 'appraisals' were better:

> 'I am not a great proponent of the formal appraisal process for my executive team because I constantly appraise them. I do it all the time, that's how I manage. You

> need an open culture, based on continuous learning and feedback'. (21)
> 'setting aside a couple of hours once a year to do a form appraisal fees a bit like ticking boxes. Often a pretty superficial conversation'. (16)

The DH Guidance (DH 2009) does not discuss the 'culture' for collaboratively delivering sustainable improvement in any detail. Moreover, under 'principles', it is stated that behaviour change may be required to develop a culture which fosters leadership development for quality, which includes taking succession seriously; creating consistency and transparency of process; demonstrating boldness and openness; willingness to steward talent across the system; valuing diversity across the system (27). Finally, 'vision' includes being spoilt for choice where everyone counts and we are as focused on our leadership development as on our clinical outcomes and financial management so that we provide better patient outcomes and ever increasing public confidence (DH 2009, 10). Similarly, it is necessary to achieve a reputation for 'world class leadership' with leadership development as important as finance or quality for boards where organisations have leaders who are rated as highly effective (NLC 2010, 10). This could mean that boards need to take TM more seriously, although it is very doubtful that the *means* of TM would ever rank as highly as the *ends* of clinical outcomes or quality. It also appears to require a change in culture (or attitude, or behaviour?) among managers, but this may be problematic among managers who have progressed under the 'old' cultural regime.

Our three interviews with the Trust leads on TM and leadership reported that TM regarded as important within the Trusts.

> 'Leadership development is very important within the trust and is seen as absolute priority, right from CE and Board level'. (MHT 1)

These views were broadly shared by staff in these Trusts:

> 'PD is very important and I think it is something that Trust X actually takes very seriously; X is very committed to developing people'. (APT 3)
> 'This Trust does invest heavily in leadership'. (MHT 5)
> 'Personal Development is absolutely vital to the success of the Trust'. (AT 3)

A further cultural issue was the need for 'honest conversations' and the need to deal with poor performance:

> 'So how many CE are saying to their Directors: actually let's be honest you are never going to be a CE so why would you want to go on this programme'. A small PCT CE post became vacant, ideal for a first timer, but despite over 17 eligible or 'ready now' people in region, they ended up advertising and getting someone from outside the region'. (3)

> 'Really honest feedback requires a significant cultural shift'. (7)

> 'One of the things we do appallingly in the NHS is actually deal with people who don't perform. You'll find them reincarnated somewhere else again and again and again and it brings the credibility of the system into disrepute. It puts off some of our good managers and it takes up key roles with people who can't really perform in them. It wouldn't happen in the private sector . . . and it shouldn't happen in the NHS. They would be out'. (A)

Finally, it was felt that that the old 'tm' system cast a long shadow. Some pointed to the problems of NHS 'culture' of patronage and the 'old boys network'. Others were cynical that TM would continue, or even legitimate, the 'club' principles of the NHS:

> 'Trying to rid of the old boy's network and tapping him on the shoulder'. (5)
>
> 'Glass ceilings are alive and well in the NHS'. (SFT)
> 'There is definitely an 'in crowd' and an 'out crowd' operating in the NHS'. (SFT)
>
> 'It seems to me that it is a closed circle'. (SFT)
>
> 'Nepotism is the order of the day in being promoted'. (SFT)
>
> 'I do not think TM will come to much . . . tokenism, patronage and cliques are the dominant cultural decisions'. (29)

Conclusions

It can be seen that there is no apparent shortage of vision, investment and activity for TM. It is too early to determine whether this will translate into positive results using summative evaluation. However, although both the DH and SHA documents stress that it is 'early days', there are a number of issues identified through process evaluation that may undermine the TM strategy. First, principles do not appear to have been translated into practice, and some appear to be in conflict. In particular, it is not clear whether there are sufficient levers for system change when parts of the 'system' appear less engaged than others, reflecting a deep divide between whether talent is the property of the system or organisations. Second, the initial prime focus on ACE and AD and TLP suggest an exclusive rather than an inclusive perspective, which conflicts with the view of many in the NHS (cf. Ford et al. 2010b). Third, achieving the longer term objectives of ensuring a systematic approach is in place may be problematic when many feel that TM may not have a long term, sustainable future. Fourth, there is little demonstrable evidence that process measures such as a named SHA Board director and CEO and Chair spending 20% of their time improving leadership capacity have been achieved. Fifth, our informants are far from convinced that the necessary infrastructure, culture and data for collaboratively delivering sustainable improvement is in place. Sixth, although it is 'early days', there is a lack of conceptual and empirical clarity in that definitions of 'SFC' and a representative senior leadership are far from clear. Finally, there is no robust evidence base for TM that would suggest clear guidance on 'what works' (Ford et al. 2010a, 2010b; Lewis and Heckman 2006). Moreover, some commentators stress that strategies must be contextual rather than universal 'best practice' (e.g. CIPD 2006; Ford et al. 2010a, 2010b), and there is relatively little material on public services (but see Devine and Powell 2008: White 2009).

The NHS Confederation (2009, 2) point out that there have been four reorganisation of leadership development in 10 years, which suggests that diagnosing the problem of NHS leadership is less straightforward than has been assumed: 'We would argue that debates about the need to improve management and leadership in the NHS have been going on at least since the Griffiths Report on NHS management in 1983'. In our view, 'mt' initiatives have a much longer history, but in view of previous 'false starts' the current initiative is unlikely to be the last. This means that it

is important not let the current structural reorganisation in the NHS derail the TM initiative. Nevertheless, its problems need to be addressed. In particular, we do not have a clear evidence base on 'what works' in TM, which suggests an urgent need for most robust evidence and for a summative evaluation of the initiative.

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